EXECUTIVE SUMMARY

PURPOSE

This report describes the services provided to Medicare beneficiaries who rented oxygen concentrators in 1991. We conducted this study to determine the nature and extent of these services.

BACKGROUND

Medicare coverage of home oxygen care

Medicare allowances exceeded $660 million in 1991 for oxygen concentrator rentals. Nationally, the average monthly allowance for stationary equipment including concentrators was approximately $273.

Section 1861(S)(6) of the Social Security Act prescribes coverage of durable medical equipment (DME) including home oxygen equipment and supplies under Medicare. Medicare covers home oxygen care for beneficiaries who suffer from significant hypoxemia (a deficiency in the amount of oxygen in the blood). The Health Care Financing Administration (HCFA) manages the Medicare program.

Oxygen systems

The three primary oxygen systems are (1) oxygen concentrators, (2) liquid oxygen, and (3) gaseous systems. Liquid and gaseous systems are administered directly to patients using conventional tanks or cylinders.

Designed primarily for home use, oxygen concentrators are electrically powered devices which provide long-term, life-sustaining supplemental therapy for patients with inhibited pulmonary function, such as chronic obstructive pulmonary disease. The devices provide a richer concentration of oxygen to the patient by separating atmospheric gases from room air.

Concentrators require maintenance

The delivery of effective therapy embodied in home oxygen equipment implies that suppliers perform services on an initial as well as a continuing basis to assure the delivery of therapeutic care. Generally, patients using items such as wheelchairs and hospital beds require little monitoring. In contrast, oxygen therapy patients typically require more attention in the form of periodic services from the oxygen supplier. Such services may include equipment monitoring and maintenance, emergency service, and patient instruction and assessment.

The HCFA implemented changes in the processing of DME claims (including claims for oxygen concentrator rentals) effective October 1, 1993. Under the new system, suppliers must meet certain standards to obtain a billing number. However, the new standards did not delineate minimum service requirements for beneficiaries receiving home oxygen care.

Methodology

Using a 2-stage random sample, we selected beneficiaries in 8 Medicare carrier service areas. The 8 service areas (referred to as States in this report) were Arkansas, Georgia, Kentucky, New Jersey, North Carolina, Oklahoma, Pennsylvania, and Wisconsin. Our beneficiary sample represents the total population of 220,371 Medicare beneficiaries who received oxygen concentrator therapy for at least 3 months in 1991.

FINDINGS

Home Oxygen Concentrator Therapy Necessitates Support Services.

- Oxygen concentrator usage necessitates that suppliers deliver services periodically.

- A number of national organizations have established service standards for home oxygen care.

- Standards implemented by national organizations detail specific practices suppliers should meet, including guidelines for equipment and patient care.

Some Beneficiaries Receive Extensive Services While Others Receive Few Services.

- About 77 percent of beneficiaries do not receive equipment monitoring services every 30 days.

- Nearly half of all beneficiaries--47 percent--do not receive any patient care evaluations or assessments from suppliers.

Many Beneficiaries Did Not Receive Services Endorsed By National Organizations.

- Many of the beneficiaries did not receive the recommended services endorsed by two national organizations involved in respiratory treatment--the Department of Veterans Affairs and the American Association for Respiratory Care.

Medicare Policies Contribute To The Wide Variation In Support Services.

- Current Medicare policies do not delineate specific service requirements for suppliers providing home oxygen therapy.

- Beneficiaries may not be knowledgeable enough to select suppliers who provide appropriate ongoing services.

RECOMMENDATIONS

We recommend HCFA produce a strategy to ensure that Medicare beneficiaries receive necessary care and support in connection with their oxygen therapy. We offer a range of options for HCFA to consider which include (1) educating providers and beneficiaries about the kinds of services available and recommended by national organizations, (2) promoting industry standards to ensure better and more consistent supplier practices, and (3) setting minimum service standards by requiring suppliers to meet accreditation, certification, or licensing requirements.

COMMENTS

We solicited and received comments on our draft report from HCFA and other concerned organizations, which included the National Association for Medical Equipment Services (NAMES), the Health Industry Distributors Association (HIDA), the Health Industry Manufacturers Association (HIMA), and the American Association for Respiratory Care (AARC). The full text of their comments can be found in Appendix H.

The HCFA generally agreed with our recommendation, but preferred the first option we presented. The NAMES, HIDA, and AARC agreed with our recommendation and supported the establishment of more explicit service standards.

We appreciate the positive responses we received to our recommendation. Of all the reviewers who commented on our recommendation, HCFA was the most cautious in considering options for promotion of standards or setting minimum requirements. The HCFA believes that supplier business standards, newly in place, will address some of the problems we identified. While supplier standards can be used as a foundation for required services, they are neither explicit nor comprehensive in adressing the needs of beneficiaries on oxygen therapy.

The HCFA also expressed concerns about resources required to promote or set standards. While we appreciate these concerns, we believe that innovative approaches may be possible if HCFA pursues a productive partnership with concerned organizations, such as those which commented on our report. The HCFA may wish to explore these options in more detail with such organizations before committing to a specific course of action.

We also encourage HCFA to consider ideas beyond those which we have laid out, which might also accomplish the objective of ensuring beneficiaries receive needed services. Again, collaboration with industry and beneficiary organizations might identify some of those other approaches.